State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

b. Services of Christian Science nurses.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

d. Nursing facility services for patients under 21 years of age.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

e. Emergency hospital services.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/_/ Provided: /_/ No limitations /_/ With limitations*

/XX/ Not provided.

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Local Education Agency (LEA) Services

|X| Provided: |___| No limitations |X| With limitations*

|___| Not provided.

*Description provided on attachment.

State: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided __X__ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

_X_ Provided: _X_ State Approved (Not Physician) Service Plan Allowed
__ Services Outside the Home Also Allowed

_X_ Limitations Described on Attachment

___ Not Provided.

STATE [illegible] CHART

(Note: This chart is an overview only.)

Limitations on Att. 3.1 A

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1	Inpatient hospital services	Inpatient services are covered as medically necessary except that services in an institution for mental diseases are covered only for persons under 21 years of age or for persons 65 years of age and over. Services in an institution for tuberculosis for persons under 65 are not covered. Services in the psychiatric unit or TB unit of a general hospital are covered for all age groups.	Prior authorization is required for all nonemergency hospitalization except for the first two days of obstetrical delivery or subsequent newborn care services. Certain procedures will only be authorized in an outpatient setting unless medically contraindicated. Emergency admissions require a physician's, dentist's, or podiatrist's statement supporting the admission. Emergency admissions are exempt from prior authorization, but the continuation of the hospital stay beyond the admission is subject to prior authorization by the Medi-Cal Consultant. Mental health services are identified in the Short-Doyle/Medi-Cal (SD/MC) agreement, along with the appropriate utilization controls for that delivery system. Beneficiaries may elect to receive service through either the regular Medi-Cal program or the SD/MC system.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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(Note: This chart is an overview only.)

STATE PLAN CHART

Limitations on Attachment 3-1-A
Page 1.1

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services)	TC is covered for persons 18 years of age or older who are not receiving care in a small and rural hospital. Medical necessity includes, but is not limited to, one or more of the following: 1. Intravenous therapy, including but not limited to: • single or multiple medications • blood or blood products • total parenteral nutrition • pain management • hydration Note: The clinical record must document failure of other preventive measures, failure or inappropriateness of non-intravenous medications or the patient's inadequate response to oral hydration.	Prior authorization is required for TC level of care. The attending physician must determine that the patient has been clinically stable for the 24 hours preceding admission to TC level of care. A definitive and time-limited course of treatment must be developed prior to admission by the physician assuming TC treatment management. The attending physician must perform the initial medical visit within 24 hours of the patient's admission to TC level of care. For patients admitted from acute care hospitals, if the physician assuming the responsibility for treatment management in TC was also the attending physician in the acute care hospital, the initial physician visit must occur within 72 hours.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TN NO. 96-001
SUPERSEDES
TN NO. _____

APPROVED DATE 6/11/99

EFFECTIVE DATE 1/1/96

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	2. Rehabilitative services, including physical therapy, occupational therapy, and speech therapy rendered to: A. The transitional rehabilitation patient, who, prior to admission to TC, meets all the following criteria: • Has been assessed by a physiatrist or physician otherwise skilled in rehabilitation medicine, who has provided an explicit, time-limited plan of treatment; • Has sufficient endurance to participate in a minimum of one hour a day, 5 days per week, of a single or combined rehabilitative therapy, as ordered by a physiatrist or physician otherwise skilled in rehabilitation medicine, provided by, or under the direct supervision of, a licensed or registered therapist; and	The attending physician must visit the TC patient at least twice weekly or more often as the patient's condition warrants while the patient is receiving TC level of care. A certified nurse practitioner, in collaboration with the attending physician, or physician's assistant, under the supervision of a physician, may provide non-duplicative services to TC patients. Leave of absence is covered for TC Rehabilitation patients only. TC patients require care by registered nurses on every shift.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	• Has potential to make significant functional gain in a reasonable period of time or has a caregiver available to participate in short-term training that will enable the patient to return safely to a residential environment with the caregiver's assistance. B. The transitional medical patient, who has a need for rehabilitation therapy as ordered by the physician.	Not covered by TC: • Obstetrical patients • Patients receiving anti-cancer intravenous cytotoxic drugs • Patients with highly complex multiple rehabilitation needs that include intensive social and/or psychological interventions in order to adjust to their disability or in order to be discharged safely to a residential setting • Patients with a primary psychiatric diagnosis, or any disorder resulting in behaviors that require an intensive, highly structured behavior management and/or cognitive retraining program

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	3. Wound care, including but not limited to, skin ulcers, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites requiring the implementation of a wound care plan every eight hours. Wounds that pre-existed at nursing facility-level B shall not qualify for TC level of care. Wound care management requires physician prescribed intervention by the licensed nurse and/or physical therapist beyond routine cleansing and dressing.	
	4. Respiratory treatments requiring medication administration by a licensed nurse or respiratory therapist at least every six hours.	
	5. Traction, requiring the assessment and intervention of a licensed nurse or licensed physical therapist at least every eight hours.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2a	Hospital outpatient department services and organized outpatient clinic services	The following services are covered: 1. Physician 2. Optometric 3. Psychology 4. Podiatric 5. Physical therapy 6. Occupational therapy 7. Speech pathology 8. Audiology 9. Acupuncture 10. Laboratory and X-ray 11. Blood and blood derivatives 12. Chronic hemodialysis 13. Hearing aids 14. Prosthetic and orthotic appliances 15. Durable medical equipment 16. Medical supplies 17. Prescribed drugs 18. Use of hospital facilities for physicians' services 19. Family planning 20. Adult day health care	Prior authorization is always required for physical therapy; chronic hemodialysis; purchase, rental, or repair of hearing aids if cost exceeds $25; adult day health care; surgical procedures considered to be elective; outpatient heroin detoxification; outpatient procedures such as hyperbaric O_2 therapy, psoriasis day care, pheresis, and cardiac catheterization. Prior authorization is required for psychiatry visits in excess of 8 in 120 days and for allergy injections in excess of 8 in 120 days. Speech pathology and audiology, occupational therapy, acupuncture, and psychology services are subject to the availability of MEDI labels. Routine podiatry office visits are allowed without prior authorization. All other podiatry services are subject to prior authorization. Prior authorization is required when the purchase price of durable medical equipment or prosthetic/orthotic appliances exceeds $100. Prior authorization is required when cummulative rental or repairs exceed $25.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

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(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
		All services, including physicians' services are subject to the same requirements as when provided in a nonfacility setting. Mental health services are identified in the SD/MC agreement, along with the appropriate utilization controls for that delivery system. Beneficiaries may elect to receive service through either the regular Medi-Cal program or the SD/MC system.
2b Rural health clinic services and other ambulatory services courses under the state plan.	Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Home nursing services must be furnished in accordance with a written treatment plan established by a physician or nonphysician medical practitioner. The treatment plan must be approved and reviewed every 60 days by the supervising clinic physician.
2c and 2d Federally qualified health center (FQHC) services and other ambulatory services covered under the state plan.	Physician services and home nursing services provided by a FQHC.	All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting. All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting.

* Prior authorization is not required for emergency service.
** Coverage is limited to medically necessary services.